Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

Return completed form to the GIC

Insurance Change Form – Medicare Retirees/Survivors

Only use this form if you are an existing state or municipal retiree or survivor already enrolled in a GIC Medicare plan. In order to use this form, both you and your covered spouse, if applicable, must already be enrolled in a GIC Medicare plan.

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #	Check one: ☐ Retiree ☐ Survivor Date of retirement ____/____/____
___ ___		/ /	/	For GIC Use Only
Name - Last	First		MI	
Address	City	State	Zip Code	
Name of state agency or municipality retired from	Retirees: Do you receive a monthly retirement pension from a public sector retirement plan? ☐ Yes ☐ No	Home Phone ( )	Work Phone ( )	

02 ☐ **HEALTH COVERAGE** **Effective Date: / 01 /**

Health Plan Change ☐

☐ **Health Plan Election** (Select one of the health plans below and individual or family coverage) **Insured's Medicare claim #** _____

Spouse's Medicare claim # _____

Health Plan – Medicare Retirees / Survivors

☐ **Fallon Senior Plan (HMO)**

If enrolling in this Medicare plan, the GIC will notify the plan to forward their Medicare application to you to complete and return.

☐ **Harvard Pilgrim Medicare Enhance (Indemnity)**

☐ **Health New England MedPlus (HMO)**

☐ **Tufts Medicare Complement (HMO)**

☐ **Tufts Medicare Preferred (HMO)**

☐ **UniCare State Indemnity Plan / Medicare Extension (OME) (Indemnity)**
CIC: ☐ Yes ☐ No

Coverage
☐ **Individual**
☐ **Family**

Only complete this section if you are currently enrolled in Fallon Senior Plan or Tufts Health Plan Medicare Preferred. Both you and your covered spouse, if applicable, must complete this section.

INSURED SECTION

I am the insured and wish to disenroll from the above checked plan.
Please disenroll me from (check one) effective June 30, _____ (fill in year)

☐ Fallon Senior Plan ☐ Tufts Medicare Preferred

_____
Name (Please Print)

_____
Signature

SPOUSE SECTION

I am the covered spouse of the above insured and wish to disenroll from the above checked plan.
Please disenroll me from (check one) effective June 30, _____ (fill in year)

☐ Fallon Senior Plan ☐ Tufts Medicare Preferred

_____ — —
Spouse Name (Please Print) Spouse's Social Security number

_____ _____
Signature of spouse Date

SIGNATURE REQUIRED

Deduction Authorization: I authorize my employer, or direct my pension authority , to deduct from my payroll or pension check the amount required for the coverage I have selected.
Health Insurance: I understand that once I choose a health plan, I cannot change plans until the next annual enrollment, even if my doctor or hospital leaves the plan.
Medicare Part B: I understand that if I cancel Medicare Part B coverage, I will no longer be eligible for GIC Coverage.
Survivors: If I am a surviving spouse of a GIC insured, I certify that I have not remarried and understand that if I do remarry I am no longer eligible for GIC coverage.
Retirees must collect a pension from a public sector retirement system to be eligible for GIC coverage.
Request Documentation: The GIC reserves the right to request additional documentation if necessary.

x _____
Signature of Applicant Date

FOR GIC USE ONLY:	Entered	Verified	Political Subdivision